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CONSTRUCTIVIST THERAPY WITH TRAUMATIZED CHILDREN

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I present guidelines for treating traumatized children in light of children's characteristic responses to trauma and the developmental issues that affect their ability to deal with traumatic life events. In keeping with basic constructivist concepts, I suggest a five-phase treatment model that aims toward helping the child construct a new belief system, give new meaning to the traumatic event, and cope with his or her distress. The five phases lead to changes in the child's negative conceptions, understanding of the event, sensitivity to internal stimuli (especially in the areas of emotion and sensation), and ability to exercise techniques for changing and eliminating the traumatic response.

Traumatic experiences have a potentially significant impact on children's personality development (Gillis, 1993), whether the trauma is caused by natural disasters (McFarlane, 1987) such as flooding (Newman, 1976), earthquakes (Bradburn, 1991; Galante & Foa, 1986), or hurricanes (Belter et al., 1991; Dollinger et al., 1984) or by human-made disasters such as wars (Freud & Burlingham, 1943; Garbarino et al., 1991), accidents, shootings, and other violence (Pynoos et al., 1987; Pynoos & Nader, 1988).

The essential feature of post-traumatic stress disorder (PTSD) is the development of characteristic symptoms after exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual threatened death or serious injury (American Psychiatric Association, 1994). The person's response to the event must involve intense fear, helplessness, or horror. The symptoms resulting from the exposure include persistent reexperiencing of the trauma, persistent avoidance of stimuli associated with the trauma, persistent symptoms of increased arousal, and disturbance to functioning. However, this PTSD definition is drawn from research on adults, not children. A variety of attempts have been made to clarify

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traumatic responses in children (Peterson et al., 1991; Saylor, 1993). Terr (1979, 1983, 1985), for example, identified seven significant differences between PTSD in adults and PTSD in children:

1. Children do not usually evidence the denial of reality or massive repression that characterizes adults.
2. Children do not exhibit psychic numbing.
3. Children do not experience sudden, unexpected, visual flashbacks.
4. Children's school performance generally suffers for only a few months after the trauma (versus frequently longer disruption for adults).
5. Post-traumatic reenactment of the trauma happens much more frequently with children (usually in play).
6. Time skew is more common and more dramatically expressed in children.
7. Children often demonstrate a striking foreshortening of their view of the future.

In addition to the differences in responses to trauma, it may be proposed that the definition of the traumatic event itself may be more complex for children than for adults. Children up through elementary school age, because of their cognitive and emotional characteristics, are influenced more by their immediate surroundings (i.e., family and immediate school environment) than by distant events (e.g., in the community or in other homes; Freud & Burlingham, 1943). Children 6–12 years old (what Piaget, 1955, called the "concrete operational" stage) tend to be egocentric and to view concepts as related to their own experience. These youngsters tend to assess their experiences according to their moods, specific situations, and the people around them. Children find it difficult to understand concepts such as the finality of death, the likelihood of pain as a consequence of one's actions, relativity, or the perception of danger. They feel events within the close circle of the family have a much greater impact, and even in times of disaster may be more influenced by family members' responses to the traumatic event than by their own perceptions of the catastrophe. Thus, in addition to acts of violence, accidents, and disasters, trauma can also be defined as those events construed as traumatic by the children who experienced them.

It is difficult to determine what kind of incident will have a traumatic impact on an individual child. In response to an external event that is generally considered to be of traumatic significance for adults, such as war, some children may react with fears, nightmares, and

other problematic behaviors; others may view the same war experience not as traumatic but as a challenging experience to be encountered together with their families; and still others may appreciate that the war enables them to remain in the presence of their customarily working mother's for several weeks. What these children remember later may be the cakes they ate all day long or the games they played with other family members. On the other hand, developmental components may create a situation where trauma occurs in situations that are unexpected by adults. Events such as losses or upheavals (e.g., the family cat's disappearance, the loss of a loved doll, or a severe argument between parents) may be construed by some children as traumatic events with a long-lasting and detrimental effect, leading to the development of symptoms typical of post-traumatic cases.

Hence the need for a constructivist approach to the treatment of traumatized children. Constructivism emphasizes the need to find meaning for internal, rather than external, events, in keeping with the need to view the traumatic event through the child's own eyes. Therapists always strive to appreciate each client's subjective point of view, but for children this takes on stronger significance and is especially indicated in treating traumatized children.

My goal in this article is to shift attention from the assessment of general diagnostic criteria for children's responses to trauma to more direct, individualized interventions with children based on cognitive–constructivist theory.

COGNITIVE–CONSTRUCTIVIST THERAPY WITH TRAUMATIZED CHILDREN

This article presents my personal approach to cognitive–constructivist therapy with children in general and with traumatized children in particular. Constructivism, as the theoretical framework for my model, emphasizes the person as a scientist who actively learns to conduct his or her own life through the structuring of events, facts, and experiences (Kelly, 1955). Kelly suggested that people are participants and agents who do not merely react to the world, but rather act on it. The person is a builder or, as Kelly stated, an "architect" of his or her own schemata and realities. I propose that through self-control therapy, children may be given the specific cognitive skills necessary to achieve constructivist goals. Constructivist therapists enable this process to transpire by focusing on an attempt to understand (through their own construct systems) each traumatized child's inner world, set of personal meanings, thinking style, and need for meaningful relationships.

Although an external event is by definition crucial to a traumatic experience, I believe that the way children construe the event accounts for the difference between one child who overcomes the trauma and continues to live as fully as before and another child who responds to the same traumatic event by developing symptoms and PTSD. What differentiates these two responses to trauma is not the event itself but the way an individual child attributes meaning to the event, processes it, and reconstructs it. That people construct their own reality is more important than so-called objective events (Mahoney, 1991), highlighting the important issue of how people's lives should be understood and lived (Rychlak, 1968). Constructivism, therefore, can be considered the most important feature in dealing with trauma. The trauma cannot be avoided or changed, but the way the individual processes it and deals with accompanying feelings of guilt, fear, and so on can have a critical impact on his or her ability to live a full and adaptive life after the traumatic experience.

DIFFICULTIES IN STUDYING CHILDREN'S REACTIONS TO TRAUMATIC EVENTS

The study of children's response to trauma is quite problematic. Limited information is available to psychologists who are called on to respond to the needs of children exposed to trauma, and conclusions concerning this issue have shifted over time (Vogel & Vernberg, 1993). In addition to the aforementioned complexity in delineating the types of events that evoke traumatic responses in children, several other factors contribute to the difficulty of studying children's response to trauma.

First, children exhibit a large range of behavior problems during normal development, making it difficult to distinguish between typical and atypical behavioral responses. In a study that Rahav and I are now conducting on children's responses to war as they relate to developmental variables, we have been impressed by the difficulty in differentiating between the children's increased behavior problems in response to the war and the usual problematic behaviors seen among children throughout their maturation. Behavioral problems that frequently appear in response to trauma, such as nightmares, fears, anxieties, enuresis, tics, and so on, are very common among children who have not necessarily been exposed to traumatic events (Kazdin, 1988; Lapouse & Monk, 1958).

Second, children's reactions to trauma are not unidirectional. In a study of children's responses to the 1991 Gulf war in Israel, Rahav and I found, as we had expected, a significant increase in the number

of self-reported behavior problems during the war as compared with before the war (Rahav & Ronen, 1994). However, the behavior change during the war was not unidirectional; certain behavior problems appeared or increased in frequency and prevalence, whereas others decreased or disappeared. In other words, for some children the war was traumatic and they developed behavior problems, whereas for others the war was related to overcoming prewar behavior problems, perhaps because of the children's opportunity to stay with their parents and spend time together (Lobel et al., 1993).

Third, for some children, traumatic responses are not evident during or immediately after the event itself but developed only much later (Vogel & Vernberg, 1993).

Two main trends characterizing the research literature on children's responses to traumatic events reflect the complexity of the phenomenon. Many researchers (Garbarino et al., 1991; Gramezy & Rutter, 1985; Pynoos & Nader, 1988) have reported on children's developmental impairment, pinpointing the existence of a large range of symptoms that may jeopardize future growth and development. In contrast, other investigators (Belter et al., 1991; Coles, 1987; Rahav & Ronen, 1994; Sullivan et al., 1991) have highlighted children's adaptation and habituation to their changing or changed environment. Most of the work on children's traumatic experiences has emphasized children's reactions to the event, the degree of change in their normal life routine, and whether or not they developed PTSD. Only a few studies have explored ways to help children cope with and overcome the effect of traumatic events.

After describing some basic constructivist concepts that are important for treating traumatized children, I present a cognitive–constructivist model for treating these children.

SUBJECTIVE REALITY AND MEANING FOR CHILDREN

During the last few years, debates have emerged about the efficacy of different therapies with children (Kazdin, 1988). In a meta-analysis in which they attempted to study the efficacy of cognitive therapy with children, Durlak et al. (1991) suggested that the method is more effective for older children than for younger children, who find it difficult to use abstraction or rational analysis because of developmental aspects of their thinking style (Ronen, 1992).

For example, a boy who is afraid that a dangerous animal might enter his room might be told over and over by his parents that (a) there are no big animals in the middle of the city, (b) there are bars on the windows and no one can enter, and (c) they live on the tenth

floor, where it is impossible for animals to reach. Yet, these rational arguments alone may not suffice to help the child. Additional approaches are required. For example, the child might be helped to draw a picture of a terribly frightening monster that he can put on his bed to scare away the feared animal, or he may place a toy gun and toy soldier at the foot of the bed to stand guard. A need exists to adapt the methods used to the child's way of thinking about and perceptions of the world and him- or herself, in order to enable the child to feel more secure and find more appropriate ways to construct a personal feeling of being safe. This does not imply that children cannot be treated using some cognitive methods, but rather that therapists must adapt their treatment techniques to the individual child's age, developmental stage, and personal wishes (Ronen, 1992).

The specific thinking styles and needs of children pinpoint the important contribution constructivist psychology makes to child therapy. Constructivism tends to accent the subjective point of view. Human thoughts are the product of their place and time and not the mere product of objective events (Neimeyer, 1993). Belief systems and apparent realities are socially constituted, rather than given. The treatment of even very young children may be facilitated by an approach relating to the inner, subjective point of view (i.e., one's personal meaning-making process and the constructs of one's experiences) and not to the outside reality (i.e., objective experiences or adult perceptions of children's experiences, which tend to be regarded as important in mediating the child's behavior). Relating to their inner world is essential before trying to incur a shift in the meaning children attribute to an event. As underscored by constructivist therapists, the child's goal should consist of finding a new meaning or inventing a new interpretive framework for the world (Mahoney, 1991), rather than fighting the old meaning.

Therefore, when treating traumatized children, the central effort is toward entering the child's own world through empathic understanding. Instead of looking for objective reality or valid, reliable, external information, the therapist must try to reach a workable understanding of what the event means for the child. The therapist must (within his or her own conceptual system) learn to feel what the child feels, how he or she perceives the event, what the child believes this reaction stands for, and how the child has constructed his or her own reality in a way that might be devastating in the long run. What makes the child look at the event the way he or she does? How will this view affect the child's present or future functioning? What should be done to help the child reconstruct the event into another frame of reference? Although outcome studies permit broad conclusions about the efficacy of a method, more case studies and clinical reports are

needed in order to explore in detail the techniques (e.g., types of metaphors and reconstruction strategies) used in this individualized constructivist treatment of traumatized children.

It is necessary to underscore the importance of subjective reports by the children themselves regarding their levels of distress and other emotional reactions, for the purposes of assessment and intervention. Research on different sources of evaluation has demonstrated discrepancies in the way parents, children, and teachers perceive, experience, or evaluate situations (Orvaschel et al., 1981). These characteristic incongruencies become even stronger when evaluating traumatic events (Belter et al., 1991). Studies of children's and parents' responses to disaster have shown that parents tend to underestimate their children's anxiety responses (e.g., McFarland, 1987). Researchers have concluded that whereas parents may be the most accurate source in assessing children's acting-out behaviors (e.g., aggression, obedience problems, impulsivity, and hyperactivity), they are not particularly good at evaluating children's acting-in emotional responses, such as anxiety, stress, or depression (Achenbach et al., 1987). Because acting-in reactions typify children's responses to traumatic events, it seems that we adults can only assume or guess when, what, or how children will respond to trauma. Children themselves appear to be the best source of clinical information on which to base interventions.

THE THERAPEUTIC RELATIONSHIP

Another important issue in constructivist therapy with children is the therapeutic relationship. Whereas most behavioral and cognitive therapies emphasize the role of techniques and methods, the present direction of constructivist therapy highlights the importance of the therapeutic relationship to the process of change. Safran and Segal (1990) stressed the importance of the therapeutic alliance and relationship in order to develop an ability for change. Again, with children this point cannot be overstated. A child will not continue therapy, perform the homework, or take part in the role-plays and exercises unless he or she cares for and trusts the therapist and feels safe within the relationship (Ronen, 1993a).

The role of the therapeutic relationship for traumatized children in particular can be linked to the difficulties that the adults in a child's environment often experience in coping with the trauma, and particularly in facing the child's pain. Many parents or teachers try to discourage children from talking or complaining about the traumatic event or will deny its existence. There is a tendency for these adults to take

the "let sleeping dogs lie" or "if it doesn't squeak, don't fix it" stance, acting as if something that is not discussed simply does not exist. They may believe that, in a child, emotions such as anxiety or fear are brief in duration and can be easily appeased ("If we give her something sweet to eat, she'll forget all about it").

Thus, most children being treated for trauma not only have been exposed to an event related to interpersonal relationships (e.g., the loss of a significant person, violent relationships, or the inability of adults to provide adequate support during catastrophic incidents), but also have experienced disappointment in their relationships with the adults in their lives after the trauma (e.g., because of the adults' reluctance to discuss the event or avoidance of listening to the child's painful experiences). In contrast, the therapist can be a stable, consistent, and reliable adult who allows the child to express fears and painful emotions that parents may not be able to withstand (Yule & Gold, 1993). The therapeutic relationship can provide a corrective experience for the child, promoting the reduction of guilt and anxiety.

Using constructivist therapy with children accentuates the need to facilitate development, empowering children and using their positive ability for change through metaphors, imagination, role play, and other creative means. The responsibility for change is shared between the therapist, who proposes new experiences, and the child, who needs to try them.

THERAPEUTIC SETTING

In light of the unique features of trauma, especially parents' difficulties in coping with the traumatized child, I recommend that the treatment setting be modified. Ordinarily, I treat children together with their parents, to provide an opportunity for modeling, generalization, and work on family interactions. However, in post-trauma cases, I recommend two separate tracks: therapy for the child, to foster a corrective experience with an adult (the therapist) who does not fear the child's emotions, thoughts, and behaviors, and, in parallel, counseling for the parents, to help them in their struggle to cope with their own reactions and those of their child.

A MODEL FOR TREATING TRAUMATIZED CHILDREN

In this section, I present a treatment model whose principles I have been using over the last few years to treat childhood disorders such

as enuresis, encopresis, anxiety, and sleep terror disorder (Ronen, 1993b, 1993c, in press; Ronen et al., 1992). In a controlled study that compared this therapeutic model to other modes in the treatment of enuresis, it has been found effective (Ronen et al., 1992). A full description of the model as applied to enuretic children has been provided elsewhere (Ronen & Wozner, 1995). After the 1991 Gulf War, I began applying the model to traumatized children (Ronen, in press). Impressions from clinical work with those children enabled me to adapt the original model for use in constructivist therapy with traumatized children.

As a cognitive–constructvist approach, the model focuses on the perception of the child as a scientist who learns to formulate hypotheses about what will happen under certain conditions and to evaluate the hypotheses in light of the ensuing outcomes (Kelly, 1955). In his or her role as scientist, the child uses self-recording, self-evaluating, and self-reinforcing techniques throughout the whole process of change. An emphasis on personal meaning making exposes children to the processes through which they constructed their personally relevant schemata, increasing their awareness of the way each construct has served them and challenging them to reconstruct it in a more fulfilling and satisfactory way. Children thus learn to identify what happened to them and how they responded, to change the meaning of what happened, and to construct a new reality.

The therapist who wishes to help traumatized children should direct therapy toward three main aims, two dealing with the present and the third dealing with the future. The first goal targets the immediate experience of the trauma: helping children to accept that they experienced a traumatic event; to become aware of and allow themselves to express the thoughts, emotions, and behaviors it elicited; and to try both to live with these responses and to understand that in time they could be changed. The second goal is to change the meaning (i.e., the construction) of the event in order to cope with it more effectively. The third goal is directed toward the future: helping children to grow out of the traumatic experience and empowering them to be open to the world and give other experiences a chance.

The model comprises five phases, each of which targets all three of the aims: facilitating the child's understanding and acceptance of his or her system of constructs regarding the events, helping the child to change the meaning of the situation (along with the concomitant beliefs, feelings, etc.), and challenging the child to be open to new experiences.

Phase 1: Changing Negative Conceptions

In Phase 1, the therapist tries to understand the child's own explanations and belief system concerning the traumatic event (Aim 1). He or she endeavors to help the child change the meaning of the traumatic event and construct new meanings that will improve coping. Often evident at this time are children's sense of guilt or responsibility for the traumatic event, their lack of awareness regarding their problems, and their belief that their suffering will be unremitting. The therapist should help the child articulate a reconstruction of the event, give it another meaning, and change his or her belief system (Aim 2). In contrast with the possible denial and avoidance of adults in the child's environment, the therapist should reinforce the child's belief that the event did happen and that how he or she thought, felt, or behaved in response to that event also occurred.

The child's negative conception about the interminableness of these reactions must also be addressed; the child can be introduced to the alternative that in time, these behaviors, thoughts, and feelings could be changed. A main target of this phase is to obtain the child's agreement to try working with the therapist, under the assumption that the response to the trauma is a behavior and that a behavior can be changed under certain circumstances. During this stage, the therapist can use cognitive restructuring, redefinition, metaphors, and imagination to demonstrate the accessibility of change. For example, the child's belief that "I can't, I'll never be able to cope" can be modified to "It's hard and I'm afraid, and I don't know how, but I will learn to overcome this."

Consider another example. If a child were traumatized by his father's beating him, the meaning of the event could be changed from "I was a bad boy and I made Dad angry, so he beat me up" to "It wasn't my fault; it didn't depend on anything I did; I wanted to be a good boy, but he didn't understand me and hit me." By changing the child's negative conceptions regarding self-blame, a first step is made toward helping him to stop avoidance and start exposure to new and other experiences (Aim 3).

Phase 2: Response Analysis

Often, children think they are managing well and do not need help but exhibit behavioral disorders that convey the problems they are experiencing. Therefore, a need exists to increase the child's understanding of the connection between the traumatic experience and his or her current difficulties. In this phase, the child learns to analyze

responses to the trauma within the role of a scientist who analyzes data (Kelly, 1955). The therapist helps the traumatized child analyze the process he or she underwent at a concrete, clear level according to his or her developmental abilities. The child learns to understand the progression from the frightening event experienced to the manner in which he or she reacted to it (Aim 1).

Along with this new awareness during therapy, anxiety and fear can emerge. The child may perceive him- or herself as sick or crazy when he or she experiences strange thoughts or behaves differently than usual. Emphasis in this phase of the treatment should therefore be placed on the normalcy of the way the child thinks, feels, or acts under the circumstances and on the fact that such an event is expected to elicit the thoughts that brought out this kind of behavior in the child, both at the time of the event and since then. The child is taught about the human body's flight/fight and self-preservation mechanisms and about the relation between the brain and the body in a language appropriate to his or her developmental status. Thus, therapeutic transformation begins with the development of the child's awareness of the *connection* between his or her interpretation and processing of the traumatic event and his or her ongoing bodily, emotional, cognitive, and behavioral responses (Aim 2). By gaining an understanding of his or her personal point of view and how he or she reached the point of being traumatized, the child can accept the internal source of his or her responses and therefore the responsibility for them. Traumatized children often view their problems as produced by outside precipitators; therefore, they have little hope for improvement, feeling that their difficulties are constant, everlasting, and impossible to change. A new explanation and new understanding of the situation can, in time, evoke the child's readiness to be changed (Aim 3). For example, instead of recalling an instance of flight as "I ran away," the child (after understanding the process) may understand that his or her brain "ordered me to go" and that he or she can intervene with such orders in the future.

Phase 3: Increasing Sensitivity to Internal Events

Although learning to accept and understand behaviors and thoughts is a difficult task, trying to become aware of internal sensations and to feel free to express emotions is an even more difficult challenge for children. Many children are trained, whether unintentionally or deliberately, to hide what they feel. In Phase 2, emphasis is placed on fostering children's understanding that their behaviors resulted from their feelings. Phase 3 focuses on helping the child learn to become better acquainted

with those feelings as manifested by internal messages sent by his or her own body (Aim 1). Once the distressing internal cue is identified, along with its specific location, shape, and strength, it may be related to emotions. Exercises such as "being a scientist who studies behavior" can be used in this phase to guide the child toward exploring these internal stimuli. Questions that may be asked include "What do you feel?"; "When does the sensation occur?"; "Where do you feel it?"; and "What does this mean to you?." For example, a girl who was in a traumatic car accident can learn that the pains she feels in her stomach and head make her very scared and remind her of the accident. The child must be helped to differentiate each such sensation from other types of pain and relate it to personal reasons by asking him- or herself, "When do I feel this pain? Can it be a signal that I am afraid? Does it always appear at the same time [or place or event]?" The girl who survived the car crash may discover that whenever she is expected to enter a car, she gets a stomachache, signaling that she is frightened of being involved in another crash (Aim 2). Important gains are made when the child feels able to alter the texture of these ongoing bodily and emotional experiences. Next, the child can ask, "What can I do to help the pain go away?" Merely practicing this identification process will later enable the girl to dare to enter a car and ride in it (Aim 3).

Phase 4: Empowerment Through Exercises and Change Methods

After the child has examined and learned about his or her trauma, behavior, and emotions (Aim 1), it is time for him or her to learn how to change the traumatic response. In this phase, the child is likened to an architect (Kelly, 1955), who begins reconstructing his or her life by reconfiguring the meaning of the experience (Aim 2) and becoming empowered to grow out of the experience (Aim 3). Significant progress occurs when the child feels able to experience him- or herself as an agent in his or her life stories. The child can develop new meanings, constructs, and responses that will be more effective by using techniques such as guided imagination, writing assignments, role-playing, and sculpting.

Imagination exercises could include "Imagine you are a superwoman who can do anything. What would you do?" or "Let's take a trip to the future when your problem no longer exists. What do you look like? What is different?" or "Watch a video of yourself in your mind and then use the remote control to change what needs to be changed. What would you change?"

Children can also be given writing assignments such as writing a movie script and changing its ending and its meaning and then imagining they are the movie director and casting themselves in the role in which they are most interested; writing a book about their trauma; writing a joke book about themselves; and so on.

Role-playing can help by letting the child be his or her own therapist, give a speech about him- or herself, try to catastrophize the event even more, or try to make fun of him- or herself.

Sculpting techniques help the child demonstrate the way he or she sees things. The child can be instructed, "Use your family and build a sculpture that symbolizes your feelings, thoughts, or behavior. Then change it."

These techniques are only suggestions. The best method is to have every child invent his or her own techniques, getting ideas from personal experience and his or her own way of life. For instance, if a particular child is interested in art, the therapy can use art techniques; if the child loves computers, the therapy could focus on designing a computer program for change. The possibilities are limitless. Children are very creative and have many ideas.

Phase 5: Eliminating the Traumatized Reaction

The last phase is reached as a result of making it through all of the previous ones. Learning to give a new meaning to the traumatic event, analyze undesired responses, identify internal cues, and act as an architect who confidently reconstrues his or her life culminates in the child's elimination of the traumatic reaction and forging ahead with new ways of functioning (Aims 1–3). The child has allowed him- or herself to become exposed to the situation and memories that he or she had previously avoided. Now the child can discover how to face a new reality that does not erase the trauma, but rather includes it as an integral part of life, without devastating feelings or an inability to look toward the future.

The treatment is goal directed, with the goal of facilitating change in a challenging and empowering fashion. The child is an active partner who takes chances and is ready for new experiences. The therapist directs the treatment while being sensitive, creative, responsible for the new experiences, and suggestive. The methods, emphasizing emotional and bodily sensations, are modified according to the child's areas of interest, readiness to participate, and willingness to enter into the adventure of change through metaphors and imagination.

TWO CASE EXAMPLES OF CONSTRUCTIVIST THERAPY WITH CHILDREN

Two cases illustrate the application of the model. The first example is not what one would call a trauma if one simply assessed the external event, but I will use the example to present the subjective point of view of a child who felt the event was a life-threatening trauma. This 10-old-year-boy, Matt, was referred to therapy with presenting symptoms of anxiety, fears, and avoidance behaviors. Matt's parents claimed that he had been acting traumatized, although, to the best of their knowledge, he had never been exposed to what they considered a traumatic event. Matt, on the other hand, claimed that all of his problems had begun since he got lost on family trip abroad. He described the incident, relating the fear he had felt that he would never find his parents again. He had imagined himself being kidnapped or murdered by a stranger if he dared to ask for help in finding his way back. He also emphasized the large number of rapes and murders happening every day and drew a picture of a frightening stranger of whom he was afraid. His mother argued that he had never been lost, that this was only his imagination. Still, Matt suffered from nightmares, a sleep disorder, and experiences that resembled flashbacks, and he started wetting the bed. Whatever the external event that had occurred, the boy was traumatized by the experience.

In therapy, during an exercise in supervised imagery, Matt and I took a trip to a foreign country, trying to experience what it felt like being left alone and to relive the situation of getting lost. We then acted out a role-play in which he played the part of his thoughts and I played the part of his emotions. Later, while sitting in the "therapist's chair," Matt attempted to help me look at the event as a challenging experience that tests one's sense of direction and ability to speak a foreign language and adapt to a new environment. By the end of the session, he seemed to have learned to construe things differently, announcing that what he needed to do was learn whom he could ask for help in such a situation. He even exclaimed that maybe he should actually try to get lost next time, because it seemed that it would be much less frightening than before, when he had just helplessly looked around for his parents. After a few more sessions, the nightmares ceased, as did the sleep disorder and the enuresis. We terminated therapy by drawing a map for those who do not know that one can make the best out of the experience of getting lost, and we wrote a guidebook with advice on how one can find the way back to one's family in a foreign country.

The second case example concerns an external event clearly de-

fined as a trauma according to diagnostic criteria. A 6-year-old boy, Lawrence, was referred to therapy after his father was murdered. The family had been living abroad for several years. While Lawrence was on a visit with his mother to their country of origin, his father, still abroad, was shot during a store robbery attempt. The mother, fearful of exposing her son to the traumatic event, told him that his father had been killed in a car accident and decided to move back with her son to their homeland. However, Lawrence found a newspaper with his father's picture and the whole story of the event. He was traumatized by the loss of his father but also felt insecure about his mother's fabrication and the loss of his entire familiar environment (friends, home, and school). He developed separation fears and would not let his mother out of his sight. Feelings of guilt emerged about his responsibility for the event ("Maybe if I had been with Dad he would not have died," "He died without even seeing me for the last time," "We should have taken Dad with us on our trip," etc.). He developed a sleep disorder; often cried; and became depressed, irritated, and nervous.

Therapy focused on helping Lawrence "as a scientist" to understand that there was nothing he could have done to prevent the occurrence of the murder, enabling him to change his guilt feelings. Through a process of meaning making, I helped Lawrence reconstruct the event in a way he could understand (without the need to blame either himself or his father), live with it, and find ways to cherish memories from his life with his father. Using the metaphor of an architect, he tried to design his new life in his new school with new friends, attempting to overcome his fears of being left alone or being murdered also. Through narrative and storytelling methods, he learned to accept his feelings, to expose himself to the memories of his father that he had earlier avoided, to cherish the past, and to try developing coping skills that would help him adapt himself to the new environment.

As his situation received a new interpretation (in terms of goals and steps toward change instead of deficiencies and problems in his functioning), Lawrence became eager to change things and prove he could reach his goals. He practiced role-playing in which he talked with his father, taking parts of loving the father and missing him on the one hand and being angry at him for not being careful on the other hand. During many sessions, he looked in the mirror, learning to accept his feelings, letting himself cry and be sad, and discovering which part of himself was present—the one that was angry at his father or the one that missed and cared for him—and how he could shift from one to the other. This therapy process could be termed

both form giving and meaning making in its focus. Lawrence wrote a movie script to change the end of the story, making his father a hero who survived, and later on making himself an adult who was not afraid to be in the same situation in which his father had been killed.

SUMMARY

Traumatic experiences will always be a part of human life, and there is no way to prevent children from exposure to them. I propose that traumatic experiences are a natural part of life that one must learn to accept. Instead of focusing attention on the notion that every step should be taken to avoid traumatic experiences, we should look for ways to help children live with their traumatic experiences and direct their efforts to overcome and cope with them.

If children are encouraged to give another meaning to a traumatic life event, to look at it, understand it, and process it differently, they might better develop their ability to go on with life, rather than allowing the trauma to devastate them. The traumatic event can thus even generate growth and maturation. The treatment model proposed herein aims to help children accept the trauma as part of life, to understand, reconstrue, and be aware of it, and to use their positive skills to make an effort to go on with life. The main aim, therefore, is not to overcome but to live with the trauma.

This model constitutes another step toward studying and proposing methods to help traumatized children. There is a need for controlled studies as well as case studies and clinical reports that will help therapists learn how to help children who live with fears and anxieties as a result of past traumatic experiences. Constructivist theory has great potential to become a treatment of choice for children. Unfortunately, there are not enough studies describing constructivist therapy with different kinds of childhood disorders. I hope that the present model will challenge therapists to develop constructivist approaches for children.

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